

to be attached to the surface of this tissue, taken into the lymph stream, and subjected to the cytolytic influences existing there. Lack of development of the omentum, or loss through operation, renders one less resistant to peritoneal invasion. Hemolymph glands of the splenic type existing in its base supplement the spleen if the latter be removed or its functions interfered with.

Vasovesiculectomy in Cases of Genital Tuberculosis.—BAUDET and KINDIRDJY (*Revue de Chir.*, 1906, xxvi, 749) believe that this operation is especially necessary: when there is a urinary fistula, produced and maintained by the vesicular tuberculosis; when there is rectal obstruction; when the urinary disturbances are determined by this vesiculitis and are not dependent on a cystitis; when the patients for some time under observation and treatment, medical or a previous castration, have vesicles that continue to increase in size; finally, when there exist well-marked lesions, distinctly appreciable, along the whole length of the deferential canal. Moreover, vesiculectomy appears to be the operation of choice, when one or both vesicles are very large. When the lesions of the deferential canal and of the seminal vesicles are not marked the writers do not advise vasovesiculectomy. In such a condition, according to Roux, this operation should be done to prevent the later necessity for epididymectomies and castrations, to prevent tuberculous infection of the other testicle, and to prevent a general tuberculosis. In the opinion of the authors these indications are purely theoretical, which the operation does not always fulfil. These cases appear to be especially amenable to the more economic operations on the testicle and epididymis and to medical treatment. In spite of this restriction the operative indications are very numerous and precise. There is already a strong tendency toward the operation in England, America, Switzerland, and France. Its use will undoubtedly be somewhat restrained, but Baudet and Kindirdjy are convinced that it will become classic, as has castration, in spite of the condemnation of Velpeau, and since then epididymectomies.

Operative Indications in Old Traumatism of the Head.—TIXIER (*Revue de Chir.*, 1906, xxvi, 861) says that the clinical manifestations consecutive to old injuries of the head are dependent upon a great variety of anatomical lesions, such as hypertrophy or splintering of the bone, epidural effusions of blood or serum, depressions, thickenings, or adhesions of the meninges, as well as changes in the cerebral substance. Microscopic alterations in the nervous substance also play a manifest role, as is shown by the experimental and clinical evidence. The work of Horsley has shown that excessive pressure from cerebrospinal fluid may produce exaggerated cerebrospinal excitation. Withdrawal of the fluid was followed in most cases by a disappearance or attenuation of the symptoms. Tixier thinks that an excess of cerebrospinal fluid ought to be considered in some of the more important anatomical lesions. In the case of an injury to the cranium, judged unimportant because of the lack of superficial evidence of an important lesion, but which later develops a series of complications, it is well to take into account the possibility of a previous injury to the cranium. The symptomatic indications of old traumatism are precise when the signs of localization

are directly in accord with the relics of an old fracture or contusion. The signs of Jacksonian epilepsy are the signal symptoms. Headache resisting all palliative treatment may acquire such an intensity as to make it an operative indication of the first order. There do not exist any absolute surgical contraindications. Lumbar puncture, in all cases with symptoms consecutive to old cranial injury, has an incontestable diagnostic value. It can also attenuate or cause to disappear the cerebral symptoms depending upon an excess of intracranial tension, such as the vertiges, headache, œdema of the papilla, epileptiform excesses. This operation in some cases may be followed by a cure. In the case of recurrence or of failure, complete or relative, one should not hesitate to perform a second operation. Successive operations have great importance, since the observations of patients definitely cured only after the third operation are not rare in the literature.

The Radiotherapy of Hypertrophied Prostate.—TANSART and FLEIG (*Annales des maladies des organes genito-urinaires*, 1906, xxiv, 1841) believe that in hypertrophy of the prostate distinct atrophy results from radiotherapy. Since the perineal region, which is the better for exposure to the rays, is a sensitive part, the exposure should be prudently conducted. The strength should never exceed five units of Holzknecht, the rays marking seven on the radiochronometer of Benoist. Tansart and Fleig prefer prolonged exposures, at intervals of fifteen to twenty days, with rays of moderate intensity, rather than heavy exposures at short intervals. They continue the treatment until the complete disappearance of all physical and functional troubles. Radiotherapy is particularly indicated in: prostatics who have not attained the period of retention; young prostatics; those who, having attained retention, can only urinate with the catheter, and are not obliged—from their social position—to obtain a rapid cure; those with infected bladder; and those with renal lesions.

The Technique of Operations on the Head and Neck.—CRILE (*Annals of Surgery*, 1906, xlv, 842) restricts himself to a consideration of the control of hemorrhage, and the plan and extent of dissection in malignant tumors. Four distinct methods are considered in connection with arterial hemorrhage. The head-up posture by diminishing the arterial flow is helpful, but with the patient under full anesthesia is attended with the danger of sudden and not easily controlled cerebral anemia, because of the circulation not being sufficiently under control. If full surgical anesthesia is not employed, precise dissection is hampered. The literature shows between 2 and 3 per cent. mortality from cerebral anemia, due to ligation of the external carotid artery; while the exposure and tying of the vessel requires dangerous handling of malignant tissue. The laborious task of picking up a large number of vessels from point to point by artery forceps requires an increased length of time and becomes a decided factor in the production of shock. The fourth method includes the temporary closure of the common carotid, in the head-up position, the catching of each vessel with forceps as it is cut, and the application of the pneumatic suit to prevent cerebral anemia. Air embolism is another distinct danger from the head-up position, but is avoided by accurate dissection, which is greatly favored by the